



PATIENT NAME: _____ DENTAL HISTORY

Previous Dentist _____ Phone Number _____

Do you have any dental problems now? Yes No
if yes, please describe _____

Are any of your teeth sensitive:

Hot or Cold? _____ Yes No

Sweets? _____ Yes No

Biting or Chewing? _____ Yes No

Have you noticed any mouth odors or bad tastes? _____ Yes No

Do you frequently get cold sores, blisters or any
other oral lesion? _____ Yes No

Do your gums bleed or hurt? _____ Yes No

Have your parents experienced gum disease
or tooth loss? _____ Yes No

Have you noticed any loose teeth or change
in your bite? _____ Yes No

Does food tend to become caught in between
your teeth? _____ Yes No

If yes where? _____

DO you:

Clench or grind your teeth while awake or asleep? _____ Yes No

Mouth breath while awake or asleep? _____ Yes No

Have tired jaws, especially in the morning? _____ Yes No

Smoke or chew tobacco? _____ Yes No

Feel nervous about having dental treatment? _____ Yes No

If so what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please explain _____

What did you like the most and least about your previous dental office?

What would you like us to do for you?

Is there anything that would prevent from starting dental treatment at this time?

Have you ever had:

Orthodontic treatment? _____ Yes No

Oral surgery? _____ Yes No

Periodontal treatment? _____ Yes No

Your teeth ground or bite adjustment _____ Yes No

A bite or mouth guard? _____ Yes No

Do your gums bleed or hurt? _____ Yes No

A serious injury to mouth or head? _____ Yes No

If so, please described, including cause? _____

Have you experienced:

Clicking or popping jaw? _____ Yes No

Pain? (joint, ear, side of face). _____ Yes No

Difficulty in opening or closing the mouth? _____ Yes No

Difficulty in chewing on either side of the mouth? _____ Yes No

Headaches, neckaches or shoulder aches? _____ Yes No

If you had a magic wand, what would you change
about your smile?

Shape, gap, crowding, etc. _____ Yes No

Tooth length: longer or shorter. _____ Yes No

Fillings: discolored or black _____ Yes No

Crowns/Caps: dull or dead looking. _____ Yes No

Other: _____

Are you interested in dental care that helps prevent:

Root Canals _____ Yes No

Broken Teeth _____ Yes No

Tooth Aches _____ Yes No

